1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13551

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13538

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville (Rural)
c. LENGTH OF STAY IN 1b: 8yrs.7mos.23days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 725 S. Bond Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary. Middle: Smialkowski Last: Anderson

4. DATE OF DEATH: Month: December Day: 22, Year: 19 58

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 27, 1893
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Packing House Employee
10b. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Stanislaus Krygier ~~Louis Krager~~
14. MOTHER'S MAIDEN NAME: Josephine Pilachowski ~~Sophie Polaski~~

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Catherine Scardino 406 S. Wolfe Street, Springfield State Hospital Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction with perforation of left ventricular wall.
DUE TO (b): Generalized arteriosclerosis.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Unknown Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenic reaction, paranoid type.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: a. m. p. m. Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James T. Marsh M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): James T. Marsh, M.D.
DATE SIGNED: December 22, 1958

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/26/58
22c. NAME OF CEMETERY OR CREMATORY: St. Stanislaus Cemetery
22d. LOCATION (City, town, or county) (State): 1300 Dundalk Ave, Balto, Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: George G. Weber 705 S. Conn st
24a. REC'D BY REGISTRAR DATE: 12/24/58
24b. REGISTRAR'S SIGNATURE: Arthur L. Kramer

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13552 CERTIFICATE OF DEATH

Reg. Dist. No. 13539

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 5yrs.10mos.18d.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: ~~City~~ Balto. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 7908 Hillendale Road, Balto.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Blanche — Middle Vernon — Last Archer

4. DATE OF DEATH: Month December — Day 1 — Year 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6/12/75
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Richard Archer
14. MOTHER'S MAIDEN NAME: Mary Eliz. Hobbs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): -
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Springfield Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular heart disease — INTERVAL BETWEEN ONSET AND DEATH: years
422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. assoc. with circulartory disturbance with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour o. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/20, 19 54, to 12/1/58, 19 ____, that I last saw the deceased alive on 12/1, 19 58, and that death occurred at 9:40 a.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 12/1/58

PHYSICIAN'S NAME (Type): Edmund Lusthaus, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/4/58
22c. NAME OF CEMETERY OR CREMATORY: Loudon Park
22d. LOCATION (City, town, or county) (State): Balto.

23. FUNERAL DIRECTOR'S SIGNATURE: Linton Weedefeld — ADDRESS: 500 E 22nd St
24a. REC'D BY REGISTRAR: DATE DEC 5 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

Burial

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by [redacted] funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13553 **CERTIFICATE OF DEATH** Reg. Dist. No. 13540

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville (Rural)
c. LENGTH OF STAY IN 1b: 5 y. 4 m. 9 d.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3 Va 1-4
d. STREET ADDRESS: 2002 Swansea Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Antoinette — Last: Beck
4. DATE OF DEATH: Month: December — Day: 10 — Year: 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: February 11, 1881
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Beck
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Springfield State Hospital Record

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Rheumatic heart disease — years
DUE TO
(c)
416X
491X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with disturbance of growth, metabolism or nutrition, with senile brain disease, with psychotic reaction.
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 1, 1957, to December 10, 1958, that I last saw the deceased alive on December 10, 1958, and that death occurred at 7:25 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Rita S. Glahn M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 12/10/58

PHYSICIAN'S NAME (Type): Rita S. Glahn, M. D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): 12-13-58
22b. DATE THEREOF
22c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
22d. LOCATION (City, town, or county) (State): Balto Md

23. FUNERAL DIRECTOR'S SIGNATURE: Leonard J Luck — ADDRESS: 1305 Harford

24a. REC'D BY REGISTRAR DATE: DEC 15 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
8M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13554 (Reg. Dist. No.) 13541

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Mt Airy
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Rt-144 + 40

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dickerson RD 1 10x-2
d. STREET ADDRESS: RURAL
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JAMES — Middle: HERBERT — Last: BELL
4. DATE OF DEATH: Month: Dec — Day: 13 — Year: 1958

5. SEX: male
6. COLOR OR RACE: colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-18-1932
9. AGE (In years last birthday): 26 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER-Concrete
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James Otis Bell
14. MOTHER'S MAIDEN NAME: Mildred Fredericks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 214-28-2232
17. INFORMANT: Margaret E. Bell — Address: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Comp fracture Skull - Crushing — INTERVAL BETWEEN ONSET AND DEATH: mm
816 X
DUE TO (b): injury to Chest
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Collision of M.V. with M.V.
20c. TIME OF INJURY: Hour: 1250 a. m. p. m. — Month, Day, Year: 12/13 1958
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town): Ridgeville (County): Carroll (State): Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒; and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James T. Marsh M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): JAMES T MARSH
DATE SIGNED: 12/13/58

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 12-16-58
22c. NAME OF CEMETERY OR CREMATORY: St Pauls
22d. LOCATION (City, town, or county): Della - Fred. Co. (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles E. Hicks III — ADDRESS: Frederick-Md.
24a. REC'D BY REGISTRAR DATE: DEC 22 '58
24b. REGISTRAR'S SIGNATURE: Edward L. Fowler

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13547 **CERTIFICATE OF DEATH** 13542

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster

c. LENGTH OF STAY IN 1b 6 weeks

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown 03X-2

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jordan's Convalescent Home

d. STREET ADDRESS 509 Main Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Herbert Middle Newton Last Berryman

4. DATE OF DEATH Month December Day 14 Year 1958

5. SEX M

6. COLOR OR RACE W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH July 13 1890

9. AGE (In years last birthday) 68 yrs.

IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Funeral director

10b. KIND OF BUSINESS OR INDUSTRY Self employed

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Berryman

14. MOTHER'S MAIDEN NAME Susan Elizabeth Worrell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War 1

16. SOCIAL SECURITY NO. 220-34-6042

17. INFORMANT Address Oliver C Berryman Reisterstown Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia - lobar - left lower — INTERVAL BETWEEN ONSET AND DEATH 5 days

447X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Arteriosclerosis, generalized — Years

DUE TO (c) Hypertension — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

490X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1957, to December 14, 1958, that I last saw the deceased alive on December 14, 1958 and that death occurred at 9:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Clarence E McWilliams M.D. ADDRESS (Street, city or town, state) Reisterstown, Maryland DATE SIGNED Dec 15, 1958

PHYSICIAN'S NAME (Type) Clarence E McWilliams

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF Dec 17 1958

22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery

22d. LOCATION (City, town, or county) Pikesville (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE Oliver C. Berryman ADDRESS Reisterstown, Md

24a. REC'D BY REGISTRAR DATE DEC 22 '58

24b. REGISTRAR'S SIGNATURE Arthur L. Krome

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

1

FOR STATE HEALTH DEPT.

Items 18&21 Film 299 2-25-59 ams

13543

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13543
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: 3 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 201 Sullivan Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster 27
d. STREET ADDRESS: 201 Sullivan Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lawrence — Middle: Max — Last: Beyer, Jr.

4. DATE OF DEATH: Month: December — Day: 24 — Year: 1958

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 11, 1958

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: 3 — Days: 13 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hanover, Penna.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Lawrence Max Beyer, Sr.

14. MOTHER'S MAIDEN NAME: Princess Dolly Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): - (If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT — Address: Lawrence Max Beyer, Sr.-Westminster, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): No Anatomical Cause of Death Found
795.5
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒

ACTUAL SIGNATURE: Paul F. Guerin M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED: 12-24-58

EXAMINER'S NAME (Type): Paul F. Guerin, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Dec. 27, 1958

22c. NAME OF CEMETERY OR CREMATORY: Evergreen Memorial Cemetery

22d. LOCATION (City, town, or county) (State): Harrisonburg, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers, Jr., Westminster, Md.

ADDRESS

24a. RECD BY REGISTRAR — DATE: DEC 29 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Frank

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

9VVVVVVXVV

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13555 **CERTIFICATE OF DEATH** 13544

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MAYBERRY RURAL
c. LENGTH OF STAY IN 1b: 1 WEEK
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X WESTMINSTER RURAL
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JESSIE Middle M Last BIGHAM

4. DATE OF DEATH: Month DEC Day 21 Year 1958

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: OCT 26-1883

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM BARNES

14. MOTHER'S MAIDEN NAME: ANNIE MITTEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: MRS ARTHUR DUVALL Address: WESTMINSTER RURAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial degeneration — INTERVAL BETWEEN ONSET AND DEATH: 1 yrs
420.0
DUE TO (b): Arteriosclerotic heart disease — Unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED White ot work ☐ Not while ot work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 2, 1956 to Dec 21, 1958 that I last saw the deceased alive on 12-6-, 1958, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: E. Reese Wilkens M.D. ADDRESS (Street, city or town, state): 15 Kemper ave. DATE SIGNED: 12/23/58

PHYSICIAN'S NAME (Type): E. Reese Wilkens Westminster, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 12/23/58

22c. NAME OF CEMETERY OR CREMATORY: BETHEL

22d. LOCATION (City, town, or county) (State): CARROLL Co MD

23. FUNERAL DIRECTOR'S SIGNATURE: D D Hartzler & Sons ADDRESS: New Windsor

24a. REC'D BY REGISTRAR DATE: DEC 24 '58

24b. REGISTRAR'S SIGNATURE: [illegible]

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. may be retained by the hospitol or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral dir page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13556 CERTIFICATE OF DEATH

13545
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Sykesville, Maryland
c. LENGTH OF STAY IN 1b: 3mo. 19days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore, 11
d. STREET ADDRESS: 920 W. 38th. Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: David; Middle: Thomas; Last: Bowden

4. DATE OF DEATH: Month: 12; Day: 30; Year: 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-5-1895

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watchman

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Mass.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ezra Bowden

14. MOTHER'S MAIDEN NAME: Annie Cristie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): unknown
(If yes, give war or dates of service): 1st W.W.

16. SOCIAL SECURITY NO.: 027-05-2166

17. INFORMANT: Records Springfield State Hospital — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Abscess in left lung — INTERVAL BETWEEN ONSET AND DEATH: weeks
521X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 491X
(b) Broncopneumonia-bilateral — days
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---

20c. TIME OF INJURY: Month, Day, Year; Hour o. m. p. m. --- 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ---

20f. (City or town) (County) (State): ---

21. I certify that I attended the deceased from 9-11- , 1958, to 12-30 , 1958, that I last saw the deceased alive on 12-30 , 1958, and that death occurred at 9:40 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walter Knopp M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED:
PHYSICIAN'S NAME (Type): Walter Knopp, M.D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan 3, 1959
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Ritchie Highway, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Taustine E Donovan
ADDRESS: 3818 Roland Ave

24a. REC'D BY REGISTRAR DATE: JAN 5 '59
24b. REGISTRAR'S SIGNATURE: Conrad L. Mann

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13557 CERTIFICATE OF DEATH

13546
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Woodbine
c. LENGTH OF STAY IN 1b: 11 Mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Weitzel Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City 3 V 0 1-4
d. STREET ADDRESS: 1313 Asbury Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First JOSEPH Middle SHELTON Last BRENIZE

4. DATE OF DEATH: Month 12- Day 20 Year 1958

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan.28-1891
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired-Signal Man
10b. KIND OF BUSINESS OR INDUSTRY: Penna.R.R.
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Brenize
14. MOTHER'S MAIDEN NAME: Jennie Bailey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 717-07-6260
17. INFORMANT: Nellie R.Brenize-1313 Asbury Rd. Address Baltimore 9.Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest, Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 1957 to 20 Dec 58
356.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized, Amyotrophic Lateral Sclerosis
DUE TO
(c) Severe Anemia

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1957, 19__, to 20 Dec, 1958, that I last saw the deceased alive on 20 Dec, 1958, and that death occurred at 8:30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Howard E. Hall M.D. ADDRESS (Street, city or town, state): Sykesville, Md DATE SIGNED: 20 Dec 58

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-23-58
22c. NAME OF CEMETERY OR CREMATORY: Jessops Methodist Church - Baltimore
22d. LOCATION (City, town, or county) (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Frank W. Seitz 814 W. 36th, St.
24a. REC'D BY REGISTRAR DATE: DEC 22 '58
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13558 CERTIFICATE OF DEATH

13547
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Howard Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 19 mos
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City 3V01-4
d. STREET ADDRESS: 337 S. Bentalou Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Edward Middle E. Last Brooks

4. DATE OF DEATH: Month December Day 27 Year 1958

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12-30-1896
9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Crain Hooker ...
10b. KIND OF BUSINESS OR INDUSTRY: Crown Cork & Seal
11. BIRTHPLACE (State or foreign country): Baltimore Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert M. Brooks
14. MOTHER'S MAIDEN NAME: Clara W. Ball

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -- (If yes, give war or dates of service) ----------
16. SOCIAL SECURITY NO.: 213-01-5363
17. INFORMANT: Address: Authur O. Godman-337 S. Bentalou Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH
422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Emphysema of lungs. Psychotic depressive reaction
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5-27, 1958 to 12-27, 1958 that I last saw the deceased alive on 12-26, 1958, and that death occurred at 8:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Walter Knotp M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 12-27-58
PHYSICIAN'S NAME (Type): WALTER KNOTP
Sykesville, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 31-58
22c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
22d. LOCATION (City, town, or county) (State): Baltimore Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: F. B. Wippert
ADDRESS: 1300 Eutaw Place
24a. REC'D BY REGISTRAR DATE: DEC 29 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13549

CERTIFICATE OF DEATH

13548

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: 11 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): New Windsor, Md.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First HARRY Middle T. Last Brown Sr.

4. DATE OF DEATH: Month 12 Day 11 Year 1958

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan 31 1891

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shipping Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Woolen Mills

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Curtis H. Brown

14. MOTHER'S MAIDEN NAME: Alice R. Handley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mrs. Annie Brown
Address: New Windsor

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Failure
DUE TO (b): arteriosclerosis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

450.0

INTERVAL BETWEEN ONSET AND DEATH: 6 Months / years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/1/58, 19____, to 12/11/58, 19____, that I last saw the deceased alive on 12/9/58, 19____, and that death occurred at 1:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: M.E. Robertson M.D.
ADDRESS (Street, city or town, state): New Windsor Md.
DATE SIGNED:

PHYSICIAN'S NAME (Type): M. E. Robertson
New Windsor, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-14-58
22c. NAME OF CEMETERY OR CREMATORY: Old Oakland
22d. LOCATION (City, town, or county) (State): Sykesville Carroll Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Luther A. Hughes
ADDRESS: Sykesville, Md.

24a. REC'D BY REGISTRAR DATE: DEC 17 '58
24b. REGISTRAR'S SIGNATURE: Clifton S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Nannie F. Browne **13559** **CERTIFICATE OF DEATH** Reg. Dist. No. 13549

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville (Rural)
c. LENGTH OF STAY IN 1b: 42 y. 7 m. 24 d.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 21 S. Carey Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nannie; Middle: F.; Last: Browne
4. DATE OF DEATH: Month: December; Day: 13; Year: 1958

5. SEX: Female
6. COLOR OR RACE: White
7. ~~MARRIED~~ ~~NEVER MARRIED~~ ~~DIVORCED~~ WIDOWED ☒
8. DATE OF BIRTH: September 30, 1865
9. AGE (In years last birthday): 93 yrs.
IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph R. Jeffries
14. MOTHER'S MAIDEN NAME: Miranda Hutt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT Address: Springfield State Hospital Record

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic rheumatic heart disease — INTERVAL BETWEEN ONSET AND DEATH: years

410X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Mitral stenosis — years

DUE TO

(c) Generalized arteriosclerosis — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Manic depressive reaction, depressed type.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 1, 1955, to December 13, 1958, that I last saw the deceased alive on December 13, 1958, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Elisabeth Knopp, M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 12/14/58

PHYSICIAN'S NAME (Type): Elisabeth Knopp, M. D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/16/58
22c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cem.
22d. LOCATION (City, town, or county) (State): Woodlawn, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. J. Tickner & Sons — ADDRESS: 1 to 8 Ave 17
24a. REC'D BY REGISTRAR DATE: DEC 17 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,8,9 FilmG258 1-28-59 et

13560

CERTIFICATE OF DEATH

13550

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Westminster
c. LENGTH OF STAY IN 1b: 1 Month
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Private home Route 140 Westminster RD#4

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Westminster RD #4
d. STREET ADDRESS: Route 140
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LAURA Middle MAE Last BURNE

4. DATE OF DEATH: Month DEC. Day 25 Year 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: June 21, 1886

9. AGE (In years last birthday): 72 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home-wife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Bourne, Mass.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Elmer Ryder

14. MOTHER'S MAIDEN NAME: Laura Delano

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT Address: Mrs. Russell A. Denbolder Westminster MRD#4

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hr
DUE TO
(b): Coronary Insufficiency — 24 hrs
DUE TO
(c): —

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-25, 1958, to 12-25, 1958, that I last saw the deceased alive on 12-25, 1958, and that death occurred at ___ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James T. Marsh M.D. — ADDRESS (Street, city or town, state): 105 E MAIN ST. — DATE SIGNED: 12-26-58

PHYSICIAN'S NAME (Type): JAMES T MARSH — WESTMINSTER MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: Dec 26, 58

22c. NAME OF CEMETERY OR CREMATORY: Calvert Cemetery

22d. LOCATION (City, town, or county) (State): Whitman, Mass.

23. FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers Jr. — ADDRESS: Westminster, Md.

24a. REC'D BY REGISTRAR DATE: DEC 30 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13561

CERTIFICATE OF DEATH

13551

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 14 03X-2
d. STREET ADDRESS: 8201 Harris Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LAURA — Middle VIRGINIA — Last CARR

4. DATE OF DEATH: Month 12 — Day 7 — Year 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1/24/1873

9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: — GRAY

14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 217-14-1976

17. INFORMANT — Address: Record, Springfield State Hosp., Sykes., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — 420.0 — INTERVAL BETWEEN ONSET AND DEATH: Years
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Generalized arteriosclerosis — Years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): psychotic reaction
Chronic Brain Syndrome associated with cerebral arteriosclerosis, with

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 27, 1958, to Dec. 7, 1958, that I last saw the deceased alive on Dec. 7, 1958, and that death occurred at 9:30 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gertrude M. Gross, M.D. — M.D.
PHYSICIAN'S NAME (Type): Gertrude M. Gross, M. D.
ADDRESS (Street, city or town, state): Springfield State Hospital, Sykesville, Maryland
DATE SIGNED: 12/8/58

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 12-11-58

22c. NAME OF CEMETERY OR CREMATORY: Oak Lawn

22d. LOCATION (City, town, or county) (State): Balto Md

23. FUNERAL DIRECTOR'S SIGNATURE: Leonard Luck — ADDRESS: 5305 Harford Rd

24a. REC'D BY REGISTRAR DATE: DEC 11 '58

24b. REGISTRAR'S SIGNATURE: Carlton S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG23 12-29-58 et

13562

Item 2 FilmG23 1-2-59 et

CERTIFICATE OF DEATH

Reg. Dist. No. 13552

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN]b: 5 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Pullen Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Sykesville
d. STREET ADDRESS: Second Avenue - Sykesville
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John R. Middle Marley Last Cass

4. DATE OF DEATH: Month December Day 12 Year 19 58

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Aug. 20 1868

9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Priest

10b. KIND OF BUSINESS OR INDUSTRY: Episcopal Church

11. BIRTHPLACE (State or foreign country): England

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Cass

14. MOTHER'S MAIDEN NAME: Mary Marley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: Unk

17. INFORMANT Address: Mrs R R Hoy - 505 E. 43rd St Balto 12, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis, Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH
420.1
DUE TO (b): Synerdized, Ca of Colon, intestinal Obst. — 1956 to 12 Dec 58
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO (c): Anemia.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1956, 19____, to 12 Dec, 19 58, that I last saw the deceased alive on 10 Dec 1958, 19____, and that death occurred at 10:50 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Howard E. Hall M.D. ADDRESS (Street, city or town, state): Sykesville, Md. DATE SIGNED: 12 Dec 58

PHYSICIAN'S NAME (Type): HOWARD E. HALL — Sykesville, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-15-58

22c. NAME OF CEMETERY OR CREMATORY: Lorraine Park

22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Luther H. Haight — ADDRESS: Sykesville Md

24a. REC'D BY REGISTRAR DATE: DEC 17 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13563 **CERTIFICATE OF DEATH** 13553

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 16 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bivalve 22 x 2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

15

3. NAME OF DECEASED (Type or print): First: Ara — Middle: Elizabeth — Last: Chabara
4. DATE OF DEATH: Month: 12 — Day: 14 — Year: 19 58
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-26-76
9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months: 9 Days: 18 — IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Sylvester Shockley
14. MOTHER'S MAIDEN NAME: Martha English
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: unkn
17. INFORMANT — Address: Springf. Hospit. Records

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: years
422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized arteriosclerosis — years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. assoc. with cerebral arte iosclerosis, Moder. advanced active TB
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

0

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 002X
20c. TIME OF INJURY Hour: o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-28-, 1958, to 12-13-19 58, that I last saw the deceased alive on 12-13-, 1958, and that death occurred at 7: A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 12-14-58

PHYSICIAN'S NAME (Type): Edmudn Lusthaus M.D. — Sykesville, Maryland

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/17/58
22c. NAME OF CEMETERY OR CREMATORY: Bivalve Cem.
22d. LOCATION (City, town, or county) (State): Bivalve, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: C. T. Messick, Bivalve, Md.

24a. REC'D BY REGISTRAR DATE: DEC 19 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

HR

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13564 **CERTIFICATE OF DEATH** 13554

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 14yrs.9mth16dys

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Unknown
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 13 3V01-4
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Springfield State Hospital.
d. STREET ADDRESS: 3703 Belair Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George — Middle Henry — Last Chaney

4. DATE OF DEATH: Month 12 — Day 19 — Year 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-18- 92

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Boxer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George W.Chaney

14. MOTHER'S MAIDEN NAME: Anastatia Cummings

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Hospital records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Sudden death by asphyxia — INTERVAL BETWEEN ONSET AND DEATH: seconds
921.7
DUE TO (b): a piece of meat in the throat
Conditions, if any, which gave rise to immediate couse (o), stating the underlying couse last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o): Schizophrenic reaction,paranoid type.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____ 19____, and that death occurred at 5.35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wglenn Speicher M.D. — ADDRESS (Street, city or town, state): Westminster Md — DATE SIGNED: 12/20/58

PHYSICIAN'S NAME (Type): Acting Deputy medical Examiner

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/24/58

22c. NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery

22d. LOCATION (City, town, or county) (State): Parkville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Ullrich Funeral Home 4210 Belair Road.

24a. REC'D BY REGISTRAR DATE: DEC 29 58

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13555

13565 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Taneytown
c. LENGTH OF STAY IN 1b: 1½ years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Taneytown
d. STREET ADDRESS: 1 Broad Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Roy; Middle:; Last: Collins

4. DATE OF DEATH: Month: December; Day: 21; Year: 19 58

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 1, 1917

9. AGE (In years last birthday): 41 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machine Operator

10b. KIND OF BUSINESS OR INDUSTRY: Rubber Factory

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Abram Collins

14. MOTHER'S MAIDEN NAME: Ruthie Gibson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 230-24-7611

17. INFORMANT (Address): Mrs. Grace Collins, Taneytown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b): Amyotrophic, Progressive Spinal — INTERVAL BETWEEN ONSET AND DEATH: 10 mos.?
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

356.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 491 X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/14, 19 58, to 12/21, 19 58, that I last saw the deceased alive on 12/21, 19 58, and that death occurred at 9:30 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R. S. McVaugh, M.D. — ADDRESS (Street, city or town, state): 49 Frederick St. Taneytown Md. — DATE SIGNED: 12/22/58

PHYSICIAN'S NAME (Type): R. S. McVaugh

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/26/58

22c. NAME OF CEMETERY OR CREMATORY: Pleasant Point Cemetery

22d. LOCATION (City, town, or county) (State): Tazewell, Tennessee

23. FUNERAL DIRECTOR'S SIGNATURE: Marion C. Fuss — ADDRESS: C.O.Fuss & Son, Taneytown, Maryland

24a. REC'D BY REGISTRAR DATE: DEC 24 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13566 CERTIFICATE OF DEATH

Reg. Dist. No. 13556

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 712 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Henryton State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01-4
d. STREET ADDRESS: 611 Pitcher Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marjorie — Middle: Jean — Last: Coward

4. DATE OF DEATH: Month: December — Day: 13, — Year: 19 58

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ (Sep) DIVORCED ☐

8. DATE OF BIRTH: 12-15-34

9. AGE (In years last birthday): 23 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Vernon Peacock

14. MOTHER'S MAIDEN NAME: Virginia Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Virginia Drumgole — Address: 611 Pitcher Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a). (b). and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Far advance bilateral cavitary pulmonary tbc. — INTERVAL BETWEEN ONSET AND DEATH

002X

DUE TO

Conditions, if ony, which gave rise to immediate cause (a), stating the underlying couse last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 24, 19 56, to December 13 19 58 that I last saw the deceased alive an December 13, 19 58, and that death occurred at 2:15P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: E. M. Maculans M. D. M.D. — ADDRESS (Street, city or town, state): Henryton, Maryland — DATE SIGNED: 12-13-58

PHYSICIAN'S NAME (Type): Dr. Edgars M. Maculans, Supt. — Henryton State Hospital, Henryton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Dec 16, 1958

22c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cemetery

22d. LOCATION (City, town, or county): Baltimore (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph L Russ — ADDRESS: 2222 W North Ave

24c. REC'D BY REGISTRAR DATE: 12-16-58

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13567

CERTIFICATE OF DEATH

Reg. Dist. No. 13557

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1 mon. 8 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Union Bridge,
d. STREET ADDRESS: 209 Penrose Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDITH — Middle SPAHR — Last CRAMER

4. DATE OF DEATH: Month December — Day 2 — Year 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-16-84

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: -----

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John William Cramer

14. MOTHER'S MAIDEN NAME: Rebecca Elizabeth Spahr

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: ----

17. INFORMANT Address: Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: Years
422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Psychotic depressive reaction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 24, 1958, to December 2, 1958, that I last saw the deceased alive on December 2, 1958, and that death occurred at 7:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED

PHYSICIAN'S NAME (Type): Edmund Lusthaus, M. D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 12/5/58
22c. NAME OF CEMETERY OR CREMATORY: MT HOPE
22d. LOCATION (City, town, or county) (State): WOODSBORO MD

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Powell & Hartzler, Woodsboro, Md

24a. REC'D BY REGISTRAR DATE: DEC 4 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13558

13550 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. **PLACE OF DEATH** a. COUNTY: Carroll Co — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: 15 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 45 Church St

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
d. STREET ADDRESS: 45 Church St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First MARY Middle CORINNE Last CRAWMER

4. **DATE OF DEATH**: Month Dec. Day 7 Year 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 4, 1890

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-wife

10b. KIND OF BUSINESS OR INDUSTRY: Operate clothing factory

11. BIRTHPLACE (State or foreign country): Md. Carroll Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter B. Duvall

14. MOTHER'S MAIDEN NAME: Mary E. Gilbert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-24-5250

17. INFORMANT: Phillip B. Crawmer — Address: Westminster, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary artery disease — INTERVAL BETWEEN ONSET AND DEATH: abt 1 year

420.1

DUE TO (b): Vascular disease — Several years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): none

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): none

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from June 1st, 1958, to Dec. 7th, 1958, that I last saw the deceased alive on Dec. 6th, 1958, and that death occurred at 7 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: C. L. Billingslea, M.D. — ADDRESS (Street, city or town, state): Westminster, Md. — DATE SIGNED: 12-8-58

PHYSICIAN'S NAME (Type): C. L. Billingslea

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Dec 10, 58

22c. NAME OF CEMETERY OR CREMATORY: Westminster Cemetery

22d. LOCATION (City, town, or county) (State): Westminster, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: E. E. Myers Jr. — ADDRESS: Westminster, Md.

24a. REC'D BY REGISTRAR DATE: DEC 10 '58

24b. REGISTRAR'S SIGNATURE: Carlton E. Morris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13568 **CERTIFICATE OF DEATH** 13559

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 43y.5m.15d.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: BaltimoreCity
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3 Vol-4
d. STREET ADDRESS: -----
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle A. — Last CROOKS

4. DATE OF DEATH: Month December — Day 15 — Year 1958

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-10-84
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mattress maker
10b. KIND OF BUSINESS OR INDUSTRY: Unk
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William H. Crooks
14. MOTHER'S MAIDEN NAME: Hannah Mary Fogle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: Unk.
17. INFORMANT Address: Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: Years
420.0
DUE TO
(b): Generalized arteriosclerosis — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Schizophrenic reaction, paranoid type
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 7, 1955, to December 15, 1958, that I last saw the deceased alive on December 15, 1958, and that death occurred at 10:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Agustin del Campo M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 12-15-58

PHYSICIAN'S NAME (Type): Agustin del Campo, M. D.
Sykesville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-17-58
22c. NAME OF CEMETERY OR CREMATORY: Freedom
22d. LOCATION (City, town, or county) (State): Eldersburg, Carroll Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Arthur L. Haight
ADDRESS: Sykesville, Md.

24a. REC'D BY REGISTRAR DATE: DEC 19 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Approved by Dr. James Marsh, Deputy Med. Examiner

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13569

CERTIFICATE OF DEATH

13560

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 23yrs.8mos.11days
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: Formerly-Queen Anne Rd. 3V01-4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Andrew — Middle: Alexander — Last: Danko

4. DATE OF DEATH: Month: December — Day: 31, — Year: 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 11, 1906

9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pattern Maker

10b. KIND OF BUSINESS OR INDUSTRY: Wood and Metal

11. BIRTHPLACE (State or foreign country): Mahwah, New Jersey

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: J. Michael Danko

14. MOTHER'S MAIDEN NAME: Julia Dudics

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Springfield Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial infarction due to arteriosclerotic coronary thrombosis.

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Minutes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Epilepsy without psychosis. Fracture, neck of femur, right.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify thot I ottended the deceased from October 20, 1954, to December 31, 1958, thot I lost saw the deceased olive on December 31, 1958, ond thot deoth occurred at 1:00 PM, from the couses and on the date stoted above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 12/31/58

PHYSICIAN'S NAME (Type): Edmund Lusthaus, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/3/59
22c. NAME OF CEMETERY OR CREMATORY: New Cathedral Cemetery
22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. J. Pickner & Sons — ADDRESS: Balto-17, Md.

24a. REC'D BY REGISTRAR DATE: [illegible] 5 59

24b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG237 1-9-59 et

13570

CERTIFICATE OF DEATH

13561

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 726 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Henryton State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall
d. STREET ADDRESS: Route 1, Box 9
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Gertrude — Middle: Jeanette — Last: Dashields

4. DATE OF DEATH: December 31, 1958

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 1, 1918

9. AGE (In years last birthday): 40 39 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Rock Hall, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joshua Gaines

14. MOTHER'S MAIDEN NAME: Rosie Butler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Gertrude J. Dashields - Patient — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage
002X
DUE TO
(b): Far Advanced Bilateral Pulmonary Tuberculosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 4, 1957, to December 31, 1958, that I last saw the deceased alive on December 31, 1958, and that death occurred at 5:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: E. M. Maculans M.D.
ADDRESS (Street, city or town, state): Henryton, Maryland
DATE SIGNED: 12-31-58

PHYSICIAN'S NAME (Type): Dr. Edgar M. Maculans, Supt. — Henryton State Hospital, Henryton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/2/59
22c. NAME OF CEMETERY OR CREMATORY: Shapstown Cemetery
22d. LOCATION (City, town, or county) (State): Rock Hall, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Marvin V. Williams — ADDRESS: Chestertown, Md

24a. REC'D BY REGISTRAR DATE: JAN 5 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13571 **CERTIFICATE OF DEATH**

13562 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Carroll
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 24 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 12, Md. 3V01-4
d. STREET ADDRESS: 5503 Hillen Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Joseph Middle Adam Last Dressel

4. DATE OF DEATH: Month 12 Day 28 Year 1958

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-29-94

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): shipping clerk

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John G. Dressel

14. MOTHER'S MAIDEN NAME: Katherine Lenhoff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 218-03-9129

17. INFORMANT: S.S.Hospital Records
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: years
422.1
DUE TO
(b): Generalized arteriosclerosis — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S.assoc.with cerebral arterioscler.with psych.reaction Convulsive seizures

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-4- 1958, to 12-28- 1958, that I last saw the deceased alive on 12- 28- 1958, and that death occurred at 11:10A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund B. Lusthaus M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 12-28-58

PHYSICIAN'S NAME (Type): Edmund B. Lusthaus M.D. Sykesville, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 12-31-58

22c. NAME OF CEMETERY OR CREMATORY: Moreland Park

22d. LOCATION (City, town, or county) (State): Galls Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Luther Haight Puck
ADDRESS: 5305 Harford

24a. REC'D BY REGISTRAR DATE: DEC 30 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Harris

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13572 CERTIFICATE OF DEATH

Reg. Dist. No. 13563

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Sykesville, Md.
c. LENGTH OF STAY IN 1b: 5yr.10mo.16days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase 15 x - 2
d. STREET ADDRESS: 6705 45th. Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James — Middle G — Last DuBois

4. DATE OF DEATH: Month 12 — Day 2 — Year 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-9-1878

9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookkeeper

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? unknown

13. FATHER'S NAME: Richard Catlin DuBois

14. MOTHER'S MAIDEN NAME: Alice Sophia Richardson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): unknown — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 577-03-1508

17. INFORMANT — Address: Hospital Records--Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral Pneumonia and acute cardiac — INTERVAL BETWEEN ONSET AND DEATH: 1-day
493x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) decompensation
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ———

20c. TIME OF INJURY Hour o. m. p. m. — Month — Day — Year 19 —

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ———

20f. (City or town) (County) (State): ———

21. I certify that I attended the deceased from August, 1955, to 12-2-, 1958, that I last saw the deceased alive on 12-2, 1958, and that death occurred at 7 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Walter Knopp M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 12-3-1958

PHYSICIAN'S NAME (Type): Walter Knopp, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/5/58
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A Pumphrey - Ed — ADDRESS: Bethesda - Md

24a. REC'D BY REGISTRAR DATE: DEC 8 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13573 CERTIFICATE OF DEATH

Reg. Dist. No. 13564

1. PLACE OF DEATH
a. COUNTY Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
c. LENGTH OF STAY IN 1b 56 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission)
a. STATE Md. — b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
d. STREET ADDRESS Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Clara Middle: Belle Last: Dudderar

4. DATE OF DEATH Month: December Day: 15 Year: 1958

5. SEX: F.
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 12 1876
9. AGE (In years last birthday) 82 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Beasman
14. MOTHER'S MAIDEN NAME: Maria L. Worsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 219-14-9626
17. INFORMANT: Mrs. LeRoy Keeney — Address: Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	SENILE ARTERIOSCLEROTIC NEPHROSCLEROSIS	15 yrs.
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	GENERAL ARTERIOSCLEROSIS	15 yrs.
DUE TO		
(c)	HYPERTENSIVE CARDIOVASCULAR DISEASE	20 yrs.

443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. / p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1935, 19—, to 15 December, 1958, that I last saw the deceased alive on 15 December, 1958, and that death occurred at 1:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Wm. H. Lawson, Jr., M.D. — ADDRESS (Street, city or town, state): Liberty Road at Eldersburg — DATE SIGNED: 12/15/58

PHYSICIAN'S NAME (Type) Wm. H. Lawson, Jr., M.D. — Sykesville P.O., Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	12-18-58	Springfield	Sykesville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Luther H. Haight — ADDRESS: Sykesville, Md.
24a. REC'D BY REGISTRAR DATE: DEC 22 '58
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be affixed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13574 **CERTIFICATE OF DEATH** Reg. Dist. No. 13565

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 12y.6m.3d.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01-4
d. STREET ADDRESS: ----
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NELLIE Middle BEATRICE Last DUNBAR

4. DATE OF DEATH: Month December Day 11 Year 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6-11-89
9. AGE (In years last birthday): 69 yrs. IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Saleslady
10b. KIND OF BUSINESS OR INDUSTRY: Dry Goods Store
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Clark Cawood
14. MOTHER'S MAIDEN NAME: Harriet Holmes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unk
17. INFORMANT: Records, Springfield State Hospital — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 463X Acute pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: Hours
DUE TO
(b): Thrombophlebitis, left leg — Days
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenic reaction, paranoid type

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 7, 1955, to December 11 1958, that I last saw the deceased alive on December 11, 1958, and that death occurred at 7:15 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Agustin del Campo M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 12-12-58

PHYSICIAN'S NAME (Type): Agustin del Campo
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-17-58
22c. NAME OF CEMETERY OR CREMATORY: New Cathedral
22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Luther H. Haught — ADDRESS: Sykesville, Md.
24a. REC'D BY REGISTRAR DATE: DEC 19 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13575 **CERTIFICATE OF DEATH** 13566

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 9mos. 2 days
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring, Route #2
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John — Middle William — Last Duvall, Sr.

4. DATE OF DEATH: Month December — Day 30, — Year 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED: [redacted]

8. DATE OF BIRTH: July 24, 1884

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Edward Duvall

14. MOTHER'S MAIDEN NAME: Katherine Lent

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT — Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Thrombophlebitis, right leg — INTERVAL BETWEEN ONSET AND DEATH: Months

420.0

DUE TO (b): Arteriosclerotic heart disease — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 28, 1958, to December 30, 1958, that I last saw the deceased alive an December 29, 1958, and that death accurred at 7:45 AM, from the causes and an the date stated abave.

ACTUAL SIGNATURE: Agustin del Campo M.D. — ADDRESS (Street, city or town, state): Springfield Hospital — DATE SIGNED: 12/30/58

PHYSICIAN'S NAME (Typed): Agustin delCampo, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/1/59

22c. NAME OF CEMETERY OR CREMATORY: Saraga Cemetery

22d. LOCATION (City, town, or county) (State): Saraga Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Oldfield Donaldson, Laurel, Md

24c. REC'D BY REGISTRAR DATE: JAN 5 '59

24b. REGISTRAR'S SIGNATURE: Carlton S. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13576 CERTIFICATE OF DEATH

Reg. Dist. No. 13567

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2yrs.7mos.28days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown 21032
d. STREET ADDRESS: 329 S. Mulberry St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Freda — Middle: Dorthea — Last: Gohn Free

4. DATE OF DEATH: Month: Dece mber — Day: 29 — Year: 19 58

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 5, 1880
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Penna.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lawrence ~~Lynnx~~ Gohn
14. MOTHER'S MAIDEN NAME: Caroline Rosenthal

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Springfield Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Days
331x
DUE TO
(b): Generalized arteriosclerosis — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S.assoc.with senile brain disease with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 1, 1956, to December 29, 1958, that I last saw the deceased alive on December 29, 1958, and that death occurred at 9:44A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 12/29/58

PHYSICIAN'S NAME (Type): Edmund Lusthaus, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/31/58
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or county): Hagerstown (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Rest Haven Funeral Chapel — ADDRESS: Hagerstown Md
George A. Pfingstag
24a. REC'D BY REGISTRAR: DATE DEC 31 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13577

13568 Reg. Dist. No.

FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 2/57

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Taneytown R. #2
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Westminster R#3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Vera Middle Hope Last Gamber
4. DATE OF DEATH: Month Dec. Day 3, Year 19 58
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 2,1925
9. AGE (In years last birthday): 33 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John C. Powell
14. MOTHER'S MAIDEN NAME: Bessie Unglesbee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217-20-7341
17. INFORMANT Address: Frank Gamber, Westminster, R#3, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Suicide by drowning — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Depressive phycosis — 3 months
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

975X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): suicide by drowning
20c. TIME OF INJURY (Month, Day, Year): 10:00 A.M. 12/3/58 (A.M. or P.M.)
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Monocacy River
20f. (City or town) (County) (State): Taneytown, Carroll, Maryl

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: R. J. McVaugh M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
DATE SIGNED: 12/5/58
EXAMINER'S NAME (Type): R.S.McVagh, M.D. Acting

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/6/58
22c. NAME OF CEMETERY OR CREMATORY: Pine Grove Cemetery
22d. LOCATION (City, town, or county) (State): Mt. Airy, Carroll, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J.F. Eline & Sons
ADDRESS: J.F.Eline & Sons, Reisterstown, Md.
24a. REC'D BY REGISTRAR DATE: DEC 8 '58
24b. REGISTRAR'S SIGNATURE: Carlton L. Kraus

Carroll

Taneytown R. #2

Md.

Carroll

Westminster R#3

Vera Home Dumber Dec. 5, 58

Female White X X Dec. 1955 35

Occupation own home Md. U.S.A.

John C. Powell Beagle Unplaces

no 817-23-7243 Frank Dumber, Westminster, R#3, Md.

Suicide by drowning

Depressive physosis 2 months

X

suicide by drowning

10. 10:00a.m. 12/5/58 X Monocacy River Taneytown, Carroll, Md.

X

R.S. Cvagh, M.D.

Burial 12/8/58 Pine Grove Cemetery Mt. Airy, Carroll, Md.

J.P. Zitz & Sons, Reisterstown, Md.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13578 CERTIFICATE OF DEATH

Reg. Dist. No. 13569

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 186 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Henryton State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury 22x-2
d. STREET ADDRESS: Route #2, Delaware St. Extended
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frank — Middle: — Last: Garrison

4. DATE OF DEATH: Month: December — Day: 20, — Year: 1958

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-12-1899

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Chicken Factory

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Frank Garrison, Sr.

14. MOTHER'S MAIDEN NAME: Sally Linden

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): War I

16. SOCIAL SECURITY NO.: 185-05-2433

17. INFORMANT — Address: Frank Garrison - Patient

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular disease — INTERVAL BETWEEN ONSET AND DEATH:
002X
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Moderately advanced pulmonary tuberculosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 17, 1958, to December 20 1958, that I last saw the deceased alive on December 20, 1958, and that death occurred at 1:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: E. M. Maculans M.D.
ADDRESS (Street, city or town, state): Henryton, Maryland
DATE SIGNED: 12-20-58

PHYSICIAN'S NAME (Type): Dr. Edgars M. Maculans, Supt. Henryton State Hospital, Henryton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-24-58
22c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cemetery
22d. LOCATION (City, town, or county): Fruitland (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: J. T. Stewart - Funeral Home
ADDRESS: Salisbury, Md

24a. REC'D BY REGISTRAR — DATE: DEC 29 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13579 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Reg. Dist. No. 13570

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville (rural)
c. LENGTH OF STAY IN 1b: 19y.4m.14d.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 03X-2
d. STREET ADDRESS: 3439 Everhart Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EMMA — Middle — Last HARRIS
4. DATE OF DEATH: Month December — Day 15 — Year 19 58

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Unknown
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Springfield State Hospital Record

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: ---

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Involutional psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James T. Marsh M.D.
EXAMINER'S NAME (Type): James T. Marsh, M. D.
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12-15-58

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: 12.19.58
22c. NAME OF CEMETERY OR CREMATORY: U. of M. Anatomy Board
22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Frank H. Newell, Pikesville, Md.
24a. REC'D BY REGISTRAR — DATE: DEC 24 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 2/57

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13580 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

13571 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Airy
c. LENGTH OF STAY IN 1b: 37 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Mt. Airy
d. STREET ADDRESS: N. Main
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: PAULINE — Middle: BELLE — Last: HARRISON

4. DATE OF DEATH: Month: DEC — Day: 12 — Year: 1958

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-9-1892

9. AGE (In years last birthday): 66 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Edward Crumrine

14. MOTHER'S MAIDEN NAME: Martha Virginia Alexander

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: B. C. Harrison, Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): STRANGULATION — INTERVAL BETWEEN ONSET AND DEATH: minutes
974X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hanging
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): HANGING

20c. TIME OF INJURY: Hour: 10 o. m. — Month, Day, Year: 12-12-1958

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town): Mt Airy (County): Carroll (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James T. Marsh M.D.

EXAMINER'S NAME (Type or print): JAMES T. MARSH

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 12-12-58

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 12-15-1958

22c. NAME OF CEMETERY OR CREMATORY: Pine Grove

22d. LOCATION (City, town, or county) (State): Mt. Airy, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: C. M. Waltz, ADDRESS: Winfield, Maryland

24a. REC'D BY REGISTRAR DATE: DEC 15 '58

24b. REGISTRAR'S SIGNATURE: C. Thos. L. Travers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13581 **CERTIFICATE OF DEATH** Reg. Dist. No. 13572

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
c. LENGTH OF STAY IN 1b 15y., 25d.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unknown. 3V01-4
d. STREET ADDRESS ------
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First WILLIAM Middle GEORGE Last HIDDEN

4. DATE OF DEATH Month December Day 17 Year 1958

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH 1-26-84
9. AGE (In years last birthday) 74 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Richard R. Hidden
14. MOTHER'S MAIDEN NAME Katherine Agena

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Days
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Coronary thrombosis — Days
DUE TO (c) Arteriosclerotic heart disease — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Manic depressive reaction, manic type
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 7, 1955, to December 17 1958, that I last saw the deceased alive on December 17, 1958, and that death occurred at 3:15 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE Agustin del Campo, M.D. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 12-17-58

PHYSICIAN'S NAME (Type) Agustin del Campo, M. D. Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF Dec. 21, 1958
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery
22d. LOCATION (City, town, or county) (State) St. Mary's City, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H. Sander & Sons, Inc. Baltimore, Md.
24a. REC'D BY REGISTRAR DATE DEC 23 '58
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13582 **CERTIFICATE OF DEATH** 13573

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll County — MARYLAND
Sykesville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
c. LENGTH OF STAY IN 1b 59y.7m.24d.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 0102.2
d. STREET ADDRESS ------
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Irwin		Hirsh	December	7	1958

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White		1879	79 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	West Virginia	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph Hirsh	Lina Barberger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	Unk	Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: Days

609X

DUE TO (b) Acute renal failure — Days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Urinary tract infection — Days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Mental deficiency

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from March 7, 19 55, to December 7 19 58, that I last saw the deceased alive on December 7, 19 58, and that death occurred at 11:10 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE Agustin del Campo M.D. — ADDRESS (Street, city or town, state) Springfield State Hospital — DATE SIGNED 12-7-58

PHYSICIAN'S NAME (Type) Agustin del Campo — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	12-9-58	East View	Cumberland Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Charles L. George - Cumberland, Md.	DEC 10 '58	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13583 **CERTIFICATE OF DEATH** Reg. Dist. No. 13574

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2yrs.2mos.3dys
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
d. STREET ADDRESS: R.F.D. # 3,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret — Middle: Ermina — Last: Hughes

4. DATE OF DEATH: Month: December — Day: 1 — Year: 19 58

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12/5/77

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William H. Grumbine

14. MOTHER'S MAIDEN NAME: Margaret E. SWOPE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): - (If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT — Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease. — INTERVAL BETWEEN ONSET AND DEATH: years
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. assoc. with circulatory disturbance, with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/28, 19 56, to 12/1, 19 58, that I last saw the deceased alive on 12/1, 19 58, and that death occurred at 10:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 12/1/58

PHYSICIAN'S NAME (Type): Edmund Lusthaus, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/4/58
22c. NAME OF CEMETERY OR CREMATORY: Westminster Cemetery
22d. LOCATION (City, town, or county) (State): Westminster, Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: J. E. Myers Jr., Westminster Md

24a. REC'D BY REGISTRAR DATE: DEC 4 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SS

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13584

CERTIFICATE OF DEATH

13575
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Carroll
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 21yrs.5mos.11days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01-4
d. STREET ADDRESS: S. Augusta Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Nettie; Middle Regina; Last Johenning
4. DATE OF DEATH: Month December; Day 21; Year 1958
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: October 17, 1879
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Henry Johenning, Jr.
14. MOTHER'S MAIDEN NAME: Catherine T. Gilchrist
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: Unk
17. INFORMANT: Springfield Hospital Records
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: Years
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized arteriosclerosis — Years
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Psychosis due to convulsive disorder, epileptic deterioration. Bronchopneumonia.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour o. m. p. m.; 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 20, 1954, to December 21, 1958, that I last saw the deceased alive on December 21, 1958, and that death occurred at 8:46P M. from the causes and on the date stated above.
ACTUAL SIGNATURE: Edmund Lusthaus M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 12/22/58
PHYSICIAN'S NAME (Type): Edmund Lusthaus, M.D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-23-58
22c. NAME OF CEMETERY OR CREMATORY: New Cathedral
22d. LOCATION (City, town, or county) (State): Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Luther H. Haight
ADDRESS: Sykesville, Md.
24a. REC'D BY REGISTRAR DATE: DEC 29 '58
24b. REGISTRAR'S SIGNATURE: Clarence S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13585 **CERTIFICATE OF DEATH** 13576

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester
c. LENGTH OF STAY IN 1b: 3½ yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Long Days Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Pennsylvania b. COUNTY: York
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hanover. 75X-3
d. STREET ADDRESS: 228 Broadway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lizzie Middle: Katherine Last: Jordan
4. DATE OF DEATH: Month: December Day: 27 Year: 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: August 29, 1873
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Victor Weaver
14. MOTHER'S MAIDEN NAME: Christine Reinhart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Herbert C. Jordan Address: Hanover Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardio Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
422.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Chronic Myocarditis.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 29, 1955, to Dec 27, 1958, that I last saw the deceased alive on Dec 26, 1958, and that death occurred at 8 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph E Bush M.D. ADDRESS (Street, city or town, state): Hampstead Maryland DATE SIGNED: 12-27-58

PHYSICIAN'S NAME (Type): Joseph E Bush MD Hampstead Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-30-58
22c. NAME OF CEMETERY OR CREMATORY: Mt Olivet
22d. LOCATION (City, town, or county) (State): Hanover Pa York Co

23. FUNERAL DIRECTOR'S SIGNATURE: Fred'k Bucher Hanover Pa ADDRESS:
24a. REC'D BY REGISTRAR DATE: DEC 30 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Noma

VS A1S (4)
15M 9/SS

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13586 **CERTIFICATE OF DEATH** Reg. Dist. No. 13577

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
c. LENGTH OF STAY IN 1b 6y.3m.15d.
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 Vol 4
d. STREET ADDRESS 642 Gorsuch Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: MARTHA ELIZABETH Middle: PORTER Last: KEEN
4. DATE OF DEATH Month: December Day: 12 Year: 19 58

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 5, 1868
9. AGE (In years last birthday) 90 yrs.
IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Robert Porter
14. MOTHER'S MAIDEN NAME Caroline Loar

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), ond (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: Years
4221
DUE TO
Conditions, if any, which gove rise to immediate couse (o), stoting the underlying couse lost. (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)
Pulmonary tuberculosis, moderately advanced, inactive.
C.B.S. assoc. with senile brain disease, with psychotic reaction
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.) 002X
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 7, 19 55, to December 12, 19 58, that I last saw the deceased alive on December 12, 19 58, and that death occurred at 1:45 A.M., from the causes and at the date stated above.

ACTUAL SIGNATURE Agustin del Campo M.D.
ADDRESS (Street, city or town, state) Springfield State Hospital
DATE SIGNED 12-12-58
PHYSICIAN'S NAME (Type) Agustin del Campo, M. D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 12/15/58
22c. NAME OF CEMETERY OR CREMATORY Friendship Meth. Church
22d. LOCATION (City, town, or county) Fallston, Maryland (State)

23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran ADDRESS 3000 E. Baltimore St.
24a. REC'D BY REGISTRAR DATE DEC 15 '58
24b. REGISTRAR'S SIGNATURE Arthur L. Krome

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13587 **CERTIFICATE OF DEATH** Reg. Dist. No. 13578

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 262 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Henryton State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Harve de Grace
d. STREET ADDRESS: Elizabeth Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Daniel — Middle — Last Keys

4. DATE OF DEATH: Month December — Day 14, — Year 19 58

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-22-1906

9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Middlesex, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Hezekiah Keys

14. MOTHER'S MAIDEN NAME: Annie Keys?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-01-5327

17. INFORMANT: Daniel Keys - Patient
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiovascular insufficiency — INTERVAL BETWEEN ONSET AND DEATH:
163X
DUE TO
(b): Carcinoma of both lungs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 27, 19 58, to Dec. 14, 19 58, that I last saw the deceased alive on Dec. 14, 19 58, and that death occurred at 5:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: E. M. Maculans M.D. M.D. — ADDRESS (Street, city or town, state): Henryton State Hospital — DATE SIGNED: 12-14-58

PHYSICIAN'S NAME (Type): Edgars M. Maculans, M. D. — Henryton, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): L

22b. DATE THEREOF: 12·19·58

22c. NAME OF CEMETERY OR CREMATORY: U. of M. Anatomy Board

22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Frank H. Newell — ADDRESS: Reisterstown, Md.

24a. REC'D BY REGISTRAR DATE: DEC 24 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Norris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13588 CERTIFICATE OF DEATH

Reg. Dist. No. 13579

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport 0143.2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Harry — Middle Eugene — Last Kooken

4. DATE OF DEATH: Month December — Day 3 — Year 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6/23/03

9. AGE (In years last birthday): 55 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrical Crane Opr.

10b. KIND OF BUSINESS OR INDUSTRY: Unk

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Warren Kooken

14. MOTHER'S MAIDEN NAME: Ethel C. Snyder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service): –

16. SOCIAL SECURITY NO.: Unk

17. INFORMANT: Springfield State Hospital Records — Address:

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute thrombosis of the left leg. — INTERVAL BETWEEN ONSET AND DEATH: minutes
453.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Berger's Disease — years.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenia reaction, other and unspecified

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/7 19 55 to 12/3 19 58 that I last saw the deceased alive on 12/3/58 19 , and that death occurred at 9:15a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Agustin del Campo M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 12/3/58

PHYSICIAN'S NAME (Type): Agustin delCampo, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 12-6-58 — 22c. NAME OF CEMETERY OR CREMATORY: Philos — 22d. LOCATION (City, town, or county) (State): Westernport, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Reddick Funeral Home — ADDRESS: Piedmont W. Va.

24a. REC'D BY REGISTRAR DATE: DEC 8 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13589 **CERTIFICATE OF DEATH** Reg. Dist. No. 13580

1. PLACE OF DEATH
a. COUNTY: Carroll
MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville

c. LENGTH OF STAY IN 1b: 1yr.10mos.12days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ijamsville

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

d. STREET ADDRESS: None

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Florence; Middle: Andrews; Last: Lipps

4. DATE OF DEATH: Month: December; Day: 23,; Year: 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 4, 1880

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Andrews

14. MOTHER'S MAIDEN NAME: Emma Klise

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Springfield Hospital Records
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b). and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: Years
420.0

DUE TO

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

(b) Generalized arteriosclerosis — Years.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S.assoc.with dist.of metabolism,growth or nutrition,with senile brain disease with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February 11, 1957, to December 23, 1958, that I last saw the deceased alive on December 22, 1958, and that death occurred at 7:00A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 12/23/58

PHYSICIAN'S NAME (Type): Edmund Lusthaus, M.D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-27-58
22c. NAME OF CEMETERY OR CREMATORY: Mount Olivet Cemetery
22d. LOCATION (City, town, or county) (State): Frederick, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE
ADDRESS: M. R. Etchison & Son, Frederick, Maryland

24a. REC'D BY REGISTRAR DATE: DEC 29 '58

24b. REGISTRAR'S SIGNATURE: Catherine S. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13590

CERTIFICATE OF DEATH

Reg. Dist. No. 13581

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAMPSTEAD D.
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 22 N. MAIN st

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAMPSTEAD Md
d. STREET ADDRESS: 22 N. MAIN st
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MAMIE Middle GRAY Last Lippy

4. DATE OF DEATH: Month December Day 20 Year 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: December 2, 1873
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Francis Lucas HANN
14. MOTHER'S MAIDEN NAME: GARY Price

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 218-34-0453
17. INFORMANT: Mrs Helen Lippy Gorsett Address: HAMPSTEAD Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Cardio-Vascular disease — INTERVAL BETWEEN ONSET AND DEATH

422.1

DUE TO (b): Chronic Myocarditis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 1, 1954, to Dec 20, 1958, that I last saw the deceased alive on December 19, 1958, and that death occurred at 5:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph E. Bush M.D. ADDRESS (Street), city or town, state): Hampstead Md DATE SIGNED: 12-20-58

PHYSICIAN'S NAME (Type): Joseph E. Bush MD Hampstead Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-22-1958
22c. NAME OF CEMETERY OR CREMATORY: Hampstead
22d. LOCATION (City, town, or county) (State): Carroll Co Md

23. FUNERAL DIRECTOR'S SIGNATURE: Edw E Upton ADDRESS: Hampstead Md

24a. REC'D BY REGISTRAR DATE DEC 22 1958

24b. REGISTRAR'S SIGNATURE: Edith L. Mund

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13591 **CERTIFICATE OF DEATH** Reg. Dist. No. 13582

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2yrs.7mos.9days
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 24 3V01.4
d. STREET ADDRESS: 2325 E. Fayette St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Elizabeth Middle Katherine Lost Rauh Luckert

4. DATE OF DEATH: Month December Day 19 Year 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 5, 1886
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Rauh
14. MOTHER'S MAIDEN NAME: Mary Kruger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: -
17. INFORMANT Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Rheumatic heart disease — INTERVAL BETWEEN ONSET AND DEATH: Years
416X
DUE TO
(b): Bronchopneumonia — Days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S.assoc.with brain trauma,gross force, with psychotic reaction. 491X
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 10, 1956, to December 19, 1958 that I last saw the deceased alive on December 18, 1958, and that death occurred at 3:36 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D. ADDRESS (Street, city or town, state): Springfield Hospital DATE SIGNED: 12/19/58

PHYSICIAN'S NAME (Type): Edmund Lusthaus, M.D. Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 12/22/58
22c. NAME OF CEMETERY OR CREMATORY: HOLY REDEEMER CEM.
22d. LOCATION (City, town, or county) (State): BALTO., MD.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Hartley Miller 2334 Jefferson St.
24a. REC'D BY REGISTRAR DATE: DEC 23 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13592 **CERTIFICATE OF DEATH**

Reg. Dist. No. 13583

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Howard

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville

c. LENGTH OF STAY IN 1b: 1yr10mo.4days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City 13X-2

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

d. STREET ADDRESS: 42 Main Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Mary	Rose	Schrod MADEN	December	3	1958

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White		4-28-70	88 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper	Home	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles Schrod	Katherine — ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	Unk.	S.S.H. records	Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 10 days
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Chronic brain syndrome associated with arterio-sclerosis. — Years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic brain syndrome associated with arteriosclerosis with psychotic reaction. — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 29, 1957, to December 3, 1958, that I last saw the deceased alive on December 3, 1958, and that death occurred at 4:25 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Ilse Kamm M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 12-4-58

PHYSICIAN'S NAME (Type): Ilse Kamm, M. D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	12-8-58	New Cathedral	Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Luella H. Haight — ADDRESS: Sykesville, Md.

24a. REC'D BY REGISTRAR DATE: DEC 10 '58

24b. REGISTRAR'S SIGNATURE: Caroline E. K...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13593 CERTIFICATE OF DEATH

Reg. Dist. No. 13584

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: CARROL — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: CARROLL
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - WESTMINSTER c. LENGTH OF STAY IN 1b:	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL - WESTMINSTER
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print)	First: IRENE	Middle: LORRAINE	Last: McLEMORE	4. DATE OF DEATH	Month: DEC	Day: 18	Year: 1958	
5. SEX: FEMALE	6. COLOR OR RACE: WHITE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: APR 13, 1898	9. AGE (In years last birthday): 60 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY: House wife	11. BIRTHPLACE (State or foreign country): New York, N.Y.	12. CITIZEN OF WHAT COUNTRY?: USA					
13. FATHER'S NAME: Herbert Bell	14. MOTHER'S MAIDEN NAME: Ida Green							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 090-07-2998	17. INFORMANT: Paul Ray McLemore	Address: Westminster Rd #4 Md.					

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	RESPIRATORY FAILURE	
170 X DUE TO		
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. (b)	CEREBRAL CARCINOMA, METASTATIC	
DUE TO (c)	ADENOCARCINOMA OF RIGHT BREAST	8 MO.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	VALVULAR HEART DISEASE	

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year / Hour a. m. p. m.	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			

21. I certify that I attended the deceased from MAY 9, 1958, to DEC 16 1958, that I last saw the deceased alive on DEC 16, 1958, and that death occurred at 3:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Donald E Withers M.D. ADDRESS (Street, city or town, state): 205 E. WALNUT ST. DATE SIGNED: 12/19/58

PHYSICIAN'S NAME (Type): DONALD E. WITHERS, M.D. HANOVER, PA.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Cremation	12/20/58	Charles Evans Cemetery	Reading, Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers, R. Westminster, Md. ADDRESS

24a. REC'D BY REGISTRAR DATE: DEC 22 '58

24b. REGISTRAR'S SIGNATURE: Charles S. Kuhn

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13594 CERTIFICATE OF DEATH

Reg. Dist. No. 13585

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2yrs.4mos.6days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kitzmiller, Star Route
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Annie Middle Frances Last Miller Michaels

4. DATE OF DEATH: Month December Day 23, Year 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 24, 1886

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Noah Miller

14. MOTHER'S MAIDEN NAME: Mary Kyles

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Springfield Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — Interval between onset and death: Years
420.0
DUE TO (b): Generalized arteriosclerosis — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).
C.B.S.assoc.with dist.of metabolism,growth or nutrition,with senile brain disease with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 17, 1956 to December 23, 1958, that I last saw the deceased alive on December 22, 1958, and that death occurred at 6:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 12/23/58

PHYSICIAN'S NAME (Type): Edmund Lusthaus, M.D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/26/58
22c. NAME OF CEMETERY OR CREMATORY: Taskar Cemetery
22d. LOCATION (City, town, or county) (State): Near Vindex Md.

23. FUNERAL DIRECTOR'S SIGNATURE: W. C. Leighton
ADDRESS: Oakland Md.

24a. REC'D BY REGISTRAR DATE: DEC 29 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13586

13595 **CERTIFICATE OF DEATH**

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Prince George ✓
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton c. LENGTH OF STAY IN 1b: 913 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel 1641.2
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Henryton State Hospital	d. STREET ADDRESS: 616 10th Street e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Joseph	Alphonza	Nicholson	December	28	1958

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Negro		2-3-1910	48 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Laurel, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Abraham Nicholson	Laura Heburn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	705-07-7572	Joseph Alphonza Nicholson - Patient

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebrovascular Accident	
002X DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Diabetes Mellitis and Alcoholism	
DUE TO (c)	Far Advanced Bilateral Pulmonary Tuberculosis	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

260X

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from June 28, 19 56, to December 28 19 58, that I last saw the deceased alive on December 28, 19 58, and that death occurred at 6:15A M, from the causes and on the date stated above.

ACTUAL SIGNATURE E. M. Maculans M.D. — ADDRESS (Street, city or town, state): Henryton, Maryland — DATE SIGNED: 12-28-58

PHYSICIAN'S NAME (Type) Dr. Edgars M. Maculans, Supt. — Henryton State Hospital, Henryton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Dec 31/58	Becons Chapel	Anne Arundel Co Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
R. SELBY, LAUREL, Md.	DEC 30 58	

B 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13588

13596 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: City
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville — c. LENGTH OF STAY IN 1b: 4 m 21 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 18, Md. 3V01-4
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfie d State Hospital	d. STREET ADDRESS: 709 Beltian Avenue — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Harry	W.	Pomarius	12	13	1958

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
M	W		10-7-71	87 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Lithographer		New York	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Philip Pomarius	Johanna

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
unkn	unkn	S.S Hogital Reocrds

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: days

491X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. assoc. with cerebral arterioscler. with psych. reaction Arteriosclerotic cardiovasc.disease, Uninary infection — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from 7-22-, 1958, to 12-12-, 1958, that I last saw the deceased alive on 12-12-, 1958, and that death occurred at 5:30A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 12-13-58

PHYSICIAN'S NAME (Type): Edmund Lusthaus M.D. — Sykesville, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Dec. 16, 1958	Mt. Olivet Cemetery	Baltimore Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
William Cook, Inc. 1217 St. Paul Street	DEC 17 58	Clinton L. Travis

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13597

Reg. Dist. No. 13589

1. PLACE OF DEATH
a. COUNTY: Carroll
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1y.5m.13d.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Sykesville
d. STREET ADDRESS: 1 ------
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HERSCHEL Middle Last REED

4. DATE OF DEATH: Month December Day 2 Year 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5-7-83

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): B & O Agent

10b. KIND OF BUSINESS OR INDUSTRY: B&O R. R.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Reed

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Harris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT: Address: Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: Years
422.1
DUE TO
(b): Generalized arteriosclerosis — Years
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction. Bronchopneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): 491X

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 19, 1957, to December 2, 1958, that I last saw the deceased alive on December 2, 1958, and that death occurred at 8:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Agustin del Campo M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED:

PHYSICIAN'S NAME (Type): Agustin del Campo, M. D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-5-58
22c. NAME OF CEMETERY OR CREMATORY: My Grave
22d. LOCATION (City, town, or county) (State): Ellicott City - Howard Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Luther H. Haight
ADDRESS: Sykesville, Md.

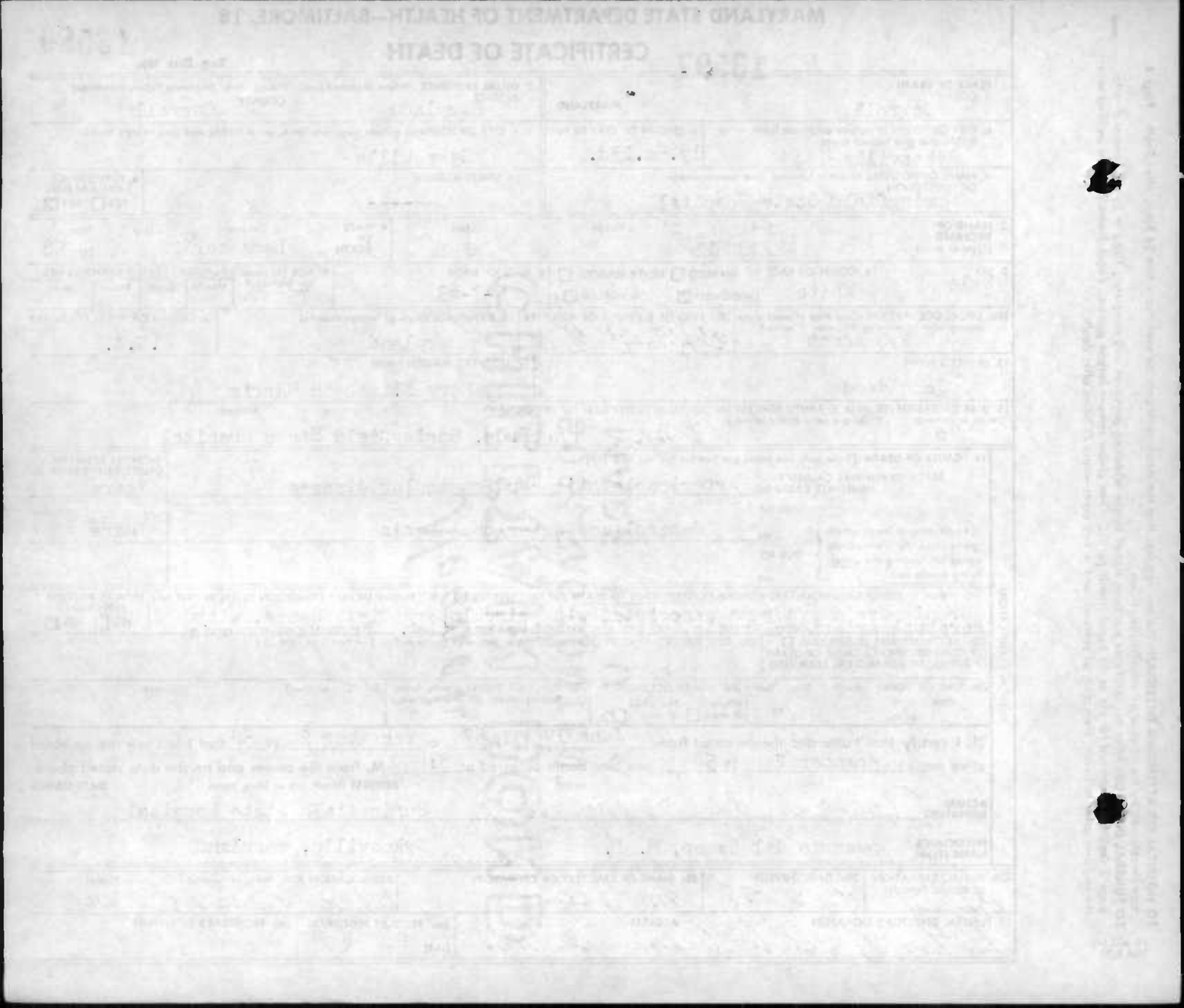
24a. REC'D BY REGISTRAR DATE: DEC 8 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13598 CERTIFICATE OF DEATH

13590

Reg. Dist. No. 74

1

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton, Maryland
c. LENGTH OF STAY IN 1b: 922 days
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Henryton State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dundalk 0353.2
d. STREET ADDRESS: 303 Tompkins Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

03

3. NAME OF DECEASED (Type or print): First: Joseph; Middle: N.; Last: Rice

4. DATE OF DEATH: Month: December; Day: 29; Year: 1958

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 30, 1918

9. AGE (In years last birthday): 40 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Fairfield, S. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Rice

14. MOTHER'S MAIDEN NAME: Beatrice Coleman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 218-07-3556

17. INFORMANT: Address: Joseph N. Rice - Patient

I

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Far advanced bilateral cavitary tuberculosis — INTERVAL BETWEEN ONSET AND DEATH
002X
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 20, 1956, to December 29, 1958, that I last saw the deceased alive on Dec. 29, 1958, and that death occurred at 1:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: E. M. Maculans M.D. M.D. — ADDRESS (Street, city or town, state): Henryton, Maryland — DATE SIGNED: 12-29-58

PHYSICIAN'S NAME (Type): E. M. Maculans, M. D. — Henryton State Hospital

22a. BURIAL, ~~CREMATION~~, REMOVAL (Specify): 1/4/59

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY: Family Lot

22d. LOCATION (City, town, or county) (State): Westminster Md

23. FUNERAL DIRECTOR'S SIGNATURE: Holland Funeral Home — ADDRESS: 163 Main St. Reisterstown Md

24a. REC'D BY REGISTRAR DATE: JAN 2 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13591

13599 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park 15 17.2
d. STREET ADDRESS: Carroll Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HELEN Middle VERDE Last ROSS

4. DATE OF DEATH: Month December Day 11 Year 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 12, 1872

9. AGE (In years last birthday): 86 ? yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Proof Reader

10b. KIND OF BUSINESS OR INDUSTRY: Pulp Assn.

11. BIRTHPLACE (State or foreign country): --- Ohio

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Ross

14. MOTHER'S MAIDEN NAME: Helen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Address: Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute renal insufficiency — INTERVAL BETWEEN ONSET AND DEATH: Days

609X

DUE TO (b) Urinary tract infection — Days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Acute brain syndrome associated with metabolic disturbance (uremia) Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): 260X

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from December 5, 1958, to December 11, 1958, that I last saw the deceased alive on December 11, 1958, and that death occurred at 4:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Agustin del Campo M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 12-11-58

PHYSICIAN'S NAME (Type): Agustin del Campo — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Dec 12, 1958

22c. NAME OF CEMETERY OR CREMATORY: GEORGE WASHINGTON CEM

22d. LOCATION (City, town, or county): Riggs Rd. HYATTSVILLE (State): MD

23. FUNERAL DIRECTOR'S SIGNATURE: Arthur L. Fields — ADDRESS: WASH 12, D.C. 754 Carroll St. NW.

24a. REC'D BY REGISTRAR: DATE DEC 15 '58

24b. REGISTRAR'S SIGNATURE: Charles L. Howard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 FilmG237 1-5-59 et

13600

CERTIFICATE OF DEATH

13592

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Mae Pullen Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: -----
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3 Vol - 4
d. STREET ADDRESS: 2900 Southern Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Emma Middle M Last Scherer

4. DATE OF DEATH: Month December Day 22nd Year 19 58

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 22, 1883
9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? Germany

13. FATHER'S NAME: Frederick Bugge
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Mrs. Ella Wortham, 2900 Southern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertension; Arteriosclerosis, — 331X — INTERVAL BETWEEN ONSET AND DEATH: 14 Dec 58
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Massive Cerebral Hemorrhage. — DUE TO
(c): Pulmonary Edema. — to 22 Dec 58

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ----- 19 57 to Dec 19 58, that I last saw the deceased alive on 22 Dec 19 58, and that death occurred at 11:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Howard E. Hall M.D. ADDRESS (Street, city or town, state): Ashworth, Md DATE SIGNED: 22 Dec 58

PHYSICIAN'S NAME (Type): Howard E. Hall

22a. BURIAL, CREMATION, REMOVAL, (Specify): Burial
22b. DATE THEREOF: 12/24/58
22c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Leonard J. Ruck 5305 Harford Road #14
24a. REC'D BY REGISTRAR DATE: DEC 24 '58
24b. REGISTRAR'S SIGNATURE: Clifford S. Fraser

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13593

13601 **CERTIFICATE OF DEATH**

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville(Rural)
c. LENGTH OF STAY IN 1b: 28 y. 8 m. 5 d.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Unknown
d. STREET ADDRESS: Unknown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: V — Last: Sessums

4. DATE OF DEATH: Month: December — Day: 12, — Year: 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 16, 1891
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months: ___ Days: ___
IF UNDER 24 HRS.: Hours: ___ Min.: ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edwin H. Russell
14. MOTHER'S MAIDEN NAME: Mary Boyd

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Springfield State Hospital Record

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: Weeks
420.1
DUE TO
(b): Myocardial degeneration — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Senile Gangrenous Ulceration — Days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Psychosis with Mental Deficiency

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 18 1958, to December 12, 1958, that I last saw the deceased alive on December 12, 1958, and that death occurred at 8:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Konstantin Weber M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 12/12/58

PHYSICIAN'S NAME (Type): Konstantin Weber, M. D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 12-15-1958
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
22d. LOCATION (City, town, or county) (State): Bladensburg Md.

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co. — ADDRESS: River Dale Md.
24a. REC'D BY REGISTRAR DATE: DEC 17 '58
24b. REGISTRAR'S SIGNATURE: Clifton L. Evans

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13594

13604 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - WESTMINSTER
c. LENGTH OF STAY IN 1b: 43 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: FINKSBURG, MD, RD#1

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER (RURAL)
d. STREET ADDRESS: FINKSBURG, MD, RD#1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RAYMOND Middle LESLIE Last SHILLING

4. DATE OF DEATH: Month DECEMBER Day 26 Year 1958

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: DECEMBER 25, 1889

9. AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER CANNER

10b. KIND OF BUSINESS OR INDUSTRY: FARMER - CANNING

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? YES

13. FATHER'S NAME: RICHARD THOMAS SHILLING

14. MOTHER'S MAIDEN NAME: MARY ELIZABETA HAFLEIGH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-28 5672

17. INFORMANT: RICHARD SHILLING (SON) Address: WESTMINSTER MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CARCINOMA OF LUNG — INTERVAL BETWEEN ONSET AND DEATH: 18 MONTAS

163X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from SEPTEMBER 1958, to DECEMBER, 1958, that I last saw the deceased alive on DECEMBER 23, 1958, and that death occurred at 2:35 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Daniel D Welliver M.D.

ADDRESS (Street, city or town, state): 19 N. CHURCH ST WESTMINSTER MARYLAND

DATE SIGNED: 12-26-58

PHYSICIAN'S NAME (Type): DANIEL D. WELLIVER

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: DEC, 29 58

22c. NAME OF CEMETERY ~~OR CREMATORY~~: CARROLLTON CHURCH CEM.

22d. LOCATION (City, town, or county) (State): Finksburg Md, RD #1

23. FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers Jr. ADDRESS: Westminster Md

24a. REC'D BY REGISTRAR DATE: DEC 30 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

CARROLL

RURAL - WESTMINSTER 43 YEARS WESTMINSTER (RURAL)

RAYMOND LESLIE SHILLING DECEMBER 31 85

MALE WHITE DECEMBER 25, 1941 44

FARMER CHURCH FARMER - CANNING MARRIED YES

RICHARD THOMAS SHILLING MARY ELIZABETH MAY-ELIOT

NO RIT-28 5872 RICHARD SHILLING (SON) MARYLAND

CARCINOMA OF LUNG 18 MONTHS

SEPTEMBER 68 DECEMBER 85

DECEMBER 25, 68 25th P

Ronald O Wallace 19 N. CHURCH ST WESTMINSTER MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13595

13605 CERTIFICATE OF DEATH

Reg. Dist. No:

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1yr.8mo.11days
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase 15X-2
d. STREET ADDRESS: 5300 Saratoga Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Ruth — Middle Elizabeth — Last Shoemaker

4. DATE OF DEATH: Month December — Day 3 — Year 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/12/93

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Government Work

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Shoemaker

14. MOTHER'S MAIDEN NAME: Sarah Perry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 214-30-0444

17. INFORMANT — Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — 422.1 — INTERVAL BETWEEN ONSET AND DEATH: years
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. assoc. with circulatory disturbance with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/22, 19 57, to 12/2, 19 58, that I last saw the deceased alive on 12/2, 19 58, and that death occurred at 5:15a.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 12/3/58

PHYSICIAN'S NAME (Type): Edmund Lusthaus, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-6-58
22c. NAME OF CEMETERY OR CREMATORY: Rockville Mausoleum
22d. LOCATION (City, town, or county) (State): Rockville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Lusthaus Haught & Sykesville, Md.
ADDRESS

24a. REC'D BY REGISTRAR — DATE: DEC 8 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13602

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13597

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: less than 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Thurmont 10x-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Harry Middle: Charles Last: Smith

4. DATE OF DEATH: Month: Dec. Day: 25 Year: 1958

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/22/1919

9. AGE (In years last birthday): 39 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): U.S.A. Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Clarence Smith

14. MOTHER'S MAIDEN NAME: Nellie Margaret Poole

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 1942-1945

16. SOCIAL SECURITY NO.: [redacted] 216-09-6500

17. INFORMANT: Address: Hospital records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral lobular pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3-4 days
491x
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Acute Brain Syndrome, org. to R Alcohol Intoxication

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State):

21. I certify that I took charge of the remains described above, held on Autopsy ☑, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James T. Mond M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 12/25/58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/29/58
22c. NAME OF CEMETERY OR CREMATORY: Bethel
22d. LOCATION (City, town, or county) (State): Hanta #1 Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Walter Y. Grove
ADDRESS: Waynesboro Pa

24a. REC'D BY REGISTRAR DATE: DEC 29 '58
24b. REGISTRAR'S SIGNATURE: Clifford L. Keefer

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13596

CERTIFICATE OF DEATH

13606 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION BRIDGE
c. LENGTH OF STAY IN 1b: YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address or INSTITUTION): RURAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION BRIDGE
d. STREET ADDRESS: RURAL
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: FANNIE — Middle: LOUISE — Last: SMITH

4. DATE OF DEATH: Month: DEC. — Day: 27 — Year: 1958

5. SEX: FEMALE

6. COLOR OR RACE: COLORED

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/11/1896

9. AGE (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEKEEPER

10b. KIND OF BUSINESS OR INDUSTRY: AT HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: WILLIAM BRIGHTFUL MILBERRY

14. MOTHER'S MAIDEN NAME: MARTHA BRIGHTFUL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: HENRY CLAY SMITH — Address: UNION BRIDGE MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocarditis — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
550.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Acute appendicitis + Peritonitis
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 16, 1958, to 12-26, 1958, that I last saw the deceased alive on 12-26, 1958, and that death occurred at 3 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: T. H. Legg M.D. — ADDRESS (Street, city or town, state): Clinton Bldg — DATE SIGNED: 12-27-58

PHYSICIAN'S NAME (Type): T. H. WEGG M.D. — UNION BRIDGE, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 22b. DATE THEREOF: 12/29/58 — 22c. NAME OF CEMETERY OR CREMATORY: MT. OLIVE — 22d. LOCATION (City, town, or county) (State): FREDERICK COUNTY MD

23. FUNERAL DIRECTOR'S SIGNATURE: D. D. Hartzler & Sons — ADDRESS: Union Bridge Md

24a. REC'D BY REGISTRAR DATE: DEC 30 '58 — 24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by [redacted] funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13603

13598 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
c. LENGTH OF STAY IN 1b 1 yr.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 V 01 - 4
d. STREET ADDRESS 821 Union Ave e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Laura Middle Belle Last Hoover SPRAGUE
4. DATE OF DEATH Month 12 Day 7 Year 1958
5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 3-21-74
9. AGE (In years last birthday) 84 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Housewife
11. BIRTHPLACE (State or foreign country) Tennessee
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Wm Hoover
14. MOTHER'S MAIDEN NAME Emily J. Steffy
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Hospital Records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH Days
609X
DUE TO (b) Urinary Tract Infection ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 902.7
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Cerebral hiteriosclerosis with psychotic reaction - Frac. left hip
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from chair
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 11-30 1958
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) S. S. H.
20f. (City or town) Sykesville (County) Carroll (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE James T. Marsh M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 12-7-58
EXAMINER'S NAME (Type) JAMES T MARSH

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Dec 11-1958
22c. NAME OF CEMETERY OR CREMATORY St. Marys (Hampden)
22d. LOCATION (City, town, or county) (State) Baltimore Maryland

23. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home Horace P. Burgee
ADDRESS 3631 Falls Road
24a. REC'D BY REGISTRAR DATE DEC 10 '58
24b. REGISTRAR'S SIGNATURE Cathryn E. Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13607 — Reg. Dist. No. 13599

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2lyrs.9mos.20days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore (28) 0352 2
d. STREET ADDRESS: 904 Prestwood Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Sylvester — Middle — Lost Stockbridge

4. DATE OF DEATH: Month December — Day 22, — Year 19 58

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 7, 1905

9. AGE (In years last birthday): 53 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jason W. Stockbridge

14. MOTHER'S MAIDEN NAME: Cora Bowersock

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
If yes, give war or dates of service: -

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Springfield Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: Years
420.0
DUE TO
(b): Generalized arteriosclerosis — Years
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenia, paranoid type.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 7, 1955, to December 22, 1958, that I last saw the deceased alive on December 21, 19 58, and that death occurred at 12:55 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Agustin del Campo M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 12/22/58

PHYSICIAN'S NAME (Type): Agustin delCampo, M.D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 23. 1958
22c. NAME OF CEMETERY OR CREMATORY: London Park
22d. LOCATION (City, town, or county) (State): Balto Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John F. Teufel
ADDRESS: 5311 Edmondson Ave

24a. REC'D BY REGISTRAR DATE: DEC 23 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13608

CERTIFICATE OF DEATH

Reg. Dist. No. 14425

1. PLACE OF DEATH
a. COUNTY ~~Baltimore~~ Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
c. LENGTH OF STAY IN 1b 11yrs.10mos.25days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4
d. STREET ADDRESS 711 S.Broadway e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Kelly Middle Unknown Last Stoeoff

4. DATE OF DEATH Month December Day 30, Year 1958

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 69 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipyard worker
10b. KIND OF BUSINESS OR INDUSTRY -
11. BIRTHPLACE (State or foreign country) Turkey
12. CITIZEN OF WHAT COUNTRY? Turkey

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -
16. SOCIAL SECURITY NO. -
17. INFORMANT Address Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic lymphatic leukemia — INTERVAL BETWEEN ONSET AND DEATH Years
2040
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Syphilitic meningo-encephalitis. 025x
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 7, 1955, to December 30, 1958, that I last saw the deceased alive on December 29, 1958, and that death occurred at 1:30A M, from the causes and on the date stated above.

ACTUAL SIGNATURE Agustin del Campo M.D. ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED 12/30/58

PHYSICIAN'S NAME (Type) Agustin delCampo, M.D. Sykesville, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify) L
22b. DATE THEREOF 12.31.58
22c. NAME OF CEMETERY OR CREMATORY U. of Md. Med. School
22d. LOCATION (City, town, or county) (State) Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE F H Jewell ADDRESS
24a. REC'D BY REGISTRAR DATE JAN 7 '59
24b. REGISTRAR'S SIGNATURE Clinton L. Frank

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13609

CERTIFICATE OF DEATH

Reg. Dist. No. 13600

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1yr.6mos.24days
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 13
d. STREET ADDRESS: 2041 Ellsworth St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Edward Middle Joseph Lost Stresewski

4. DATE OF DEATH: Month December Day 18, Year 1958

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: February 9, 1879
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumbing Helper
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: 220-01-6087
17. INFORMANT: Springfield Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Lymphocytic leukemia — INTERVAL BETWEEN ONSET AND DEATH: Years
204.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S.assoc.with cerebral arteriosclerosis with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. / p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 24, 1957, to December 18, 1958, that I last saw the deceased alive on December 18, 1958, and that death occurred at 10:32 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 12/19/58

PHYSICIAN'S NAME (Type): Edmund Lusthaus, M.D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: 12/22/58
22c. NAME OF CEMETERY OR CREMATORY: Moreland Park
22d. LOCATION (City, town, or county) (State): Balto Md

23. FUNERAL DIRECTOR'S SIGNATURE: Lemard J Luck
ADDRESS: 5305 Harford

24a. REC'D BY REGISTRAR DATE: DEC 22 '58
24b. REGISTRAR'S SIGNATURE: Catherine L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 FilmG257 12-29-58 et

13610

CERTIFICATE OF DEATH

13601

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville (Rt. # 2)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Grandview Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01-4
d. STREET ADDRESS: 4430 Pen Lucy Road #29
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Hannah Middle: E. Last: Thiel

4. DATE OF DEATH: Month: Dec. Day: 18 Year: 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐

8. DATE OF BIRTH: May 25, 1872

9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Dismas Schmidt

14. MOTHER'S MAIDEN NAME: Fannie Roesche

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Address: Mrs. Hildegarde Arnold-3504 Marmon Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): PARALYSIS AGITANS — INTERVAL BETWEEN ONSET AND DEATH: 6 yrs

350x

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State):

21. I certify that I attended the deceased from 5.15.56, 19____, to 12.18.58, 19____, that I last saw the deceased alive on 12.18.58, 19____, and that death occurred at 8 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm H Lawson M.D.

ADDRESS (Street, city or town, state): Liberty Road at Eldersburg

DATE SIGNED: 12/18/58

PHYSICIAN'S NAME (Type): Wm. H. Lawson, Jr., M.D.

Sykesville P.O., Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/22/58

22c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery

22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. J. Tobin & Son

ADDRESS: Balto 17 Md.

24a. REC'D BY REGISTRAR DATE: 12/22/58

24b. REGISTRAR'S SIGNATURE: R. Wheeler Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13611 **CERTIFICATE OF DEATH** 13602

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Sykesville
c. LENGTH OF STAY IN 1b Life
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Rural-Sykesville
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Christine Middle: M. Lost: WILSON

4. DATE OF DEATH Month: Dec. Day: 27 Year: 1958

5. SEX F. 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ 8. DATE OF BIRTH Sept. 2, 1883 9. AGE (In years last birthday) 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Home 11. BIRTHPLACE (State or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jacob Magin 14. MOTHER'S MAIDEN NAME York -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) - 16. SOCIAL SECURITY NO. None 17. INFORMANT Mrs Clyde Wilson Address Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

260X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) HYPERTENSIVE CARDIOVASCULAR DISEASE — 10 years

DUE TO

(c) DIABETES MELLITUS — 15 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1935, 19____, to 26 December, 1958, that I last saw the deceased alive on 25 December, 1958, and that death occurred at 12:02 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Wm. H. Lawson M.D. ADDRESS (Street, city or town, state) Liberty Road at Eldersburg DATE SIGNED 12.26.58.

PHYSICIAN'S NAME (Type) Wm. H. Lawson, Jr., M.D. Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 12-29-58 22c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Gardens 22d. LOCATION (City, town, or county) (State) Finksburg, Carroll Co., Md

23. FUNERAL DIRECTOR'S SIGNATURE Luther H. Haight ADDRESS Sykesville, Md

24a. REC'D BY REGISTRAR DATE JAN 5 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kime

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13612 (Reg. Dist. No.) 13603

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural--Westminster
c. LENGTH OF STAY IN 1b: 12 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Rural--Westminster
d. STREET ADDRESS: R.D. # 6
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First PAUL — Middle M. — Lost ZILE

4. DATE OF DEATH: Month DEC. — Day 10, — Year 1958

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 3-15-1903

9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farm laborer

10b. KIND OF BUSINESS OR INDUSTRY: farming

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: William D. Zile

14. MOTHER'S MAIDEN NAME: Mary E. Lovell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ?

17. INFORMANT — Address: Mr. F. A. Zile, Glencoe, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Nephritis acute — INTERVAL BETWEEN ONSET AND DEATH: 1 week
590 X
DUE TO (b):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause lost.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1, 1949, to Dec 10, 1958, that I last saw the deceased alive on Dec 10, 1958, and that death occurred at 10:15 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Julius Chepko M.D. — ADDRESS (Street, city or town, state): Westminster Md — DATE SIGNED: 12/11/58

PHYSICIAN'S NAME (Type): Julius Chepko

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 12-13-1958
22c. NAME OF CEMETERY OR CREMATORY: St. James
22d. LOCATION (City, town, or county) (State): Carroll Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: C. M. Waltz, — ADDRESS: Winfield, Md.

24a. REC'D BY REGISTRAR DATE: DEC 15 '58

24b. REGISTRAR'S SIGNATURE: Clinton L. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13613 CERTIFICATE OF DEATH

Reg. Dist. No. 13604

1. PLACE OF DEATH
a. COUNTY Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester (Rural)
c. LENGTH OF STAY IN 1b 10 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester (Rural)
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First HARRY Middle WILLIAM Last ZUSE

4. DATE OF DEATH Month Dec Day 25 Year 1958

5. SEX M

6. COLOR OR RACE W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH April 15 1877

9. AGE (In years last birthday) 81 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10b. KIND OF BUSINESS OR INDUSTRY Minister

11. BIRTHPLACE (State or foreign country) Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Augustus Zuse

14. MOTHER'S MAIDEN NAME Margaret Maisel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 171-24-5574

17. INFORMANT Address Mrs H Zuse - Manchester Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH 6 mos
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Pulmonary Embolism

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 14, 1948, to Dec 25, 1958, that I last saw the deceased alive on 12-22, 1958, and that death occurred at 3.A M, from the causes and on the date stated above.

ACTUAL SIGNATURE W. H. Foard M.D.
ADDRESS (Street, city or town, state) Manchester, Md
DATE SIGNED 12-26-58

PHYSICIAN'S NAME (Type) W. H. FOARD M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 12-29-1958
22c. NAME OF CEMETERY OR CREMATORY New Freedom
22d. LOCATION (City, town, or county) (State) York Co Penna

23. FUNERAL DIRECTOR'S SIGNATURE Edw C Tipton
ADDRESS Hampstead Md

24a. REC'D BY REGISTRAR DATE DEC 29 '58
24b. REGISTRAR'S SIGNATURE Arthur S. Krama

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55